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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	03/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RHEA COUNTY	7824 RHEA COUNTY HWY DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Federal Comparative survey was conducted on February 28, 2012 through March 2, 2012. Life Care Center of Rhea County was not in substantial compliance with the requirements of 42 CFR 483 and 488, Subpart B, Requirements for Long Term Care at the time of the survey. The facility census was 83.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	1) What corrective action will be accomplished for those residents found to have been affected by The deficient practice? LPN #2 received education on providing Privacy to residents while administering Medication per gastrostomy tube by the Staff Development Coordinator (RN) on 3/15/12 to Resident #9, and all other residents. This education included the requirement to ensure the room door is closed, the privacy curtain is completely pulled, and no visitors are in the area unless otherwise preferred by the resident when care is being provided. Wound Care Nurse and the Activities Director received education on providing Privacy to residents while providing care by the Staff Development Coordinator (RN) on 3/15/12 And 3/16/12 to Resident # 1, and all other residents. This education included the requirement to ensure the room door is closed, the privacy curtain is completely pulled, and no visitors are in the area unless otherwise preferred by the resident when care is being provided.	3/23/12 3/23/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kate Duffy | CD | 3/26/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure privacy during the administration of medication for one (1) 12 residents observed during the Medication Pass (Resident #9), and failed to provide privacy during wound care for one (1) of 23 sampled residents (Resident #1). The findings include: 1. An observation during the Medication Pass conducted on 3/2/12 at 11:15 a.m. revealed Licensed Practical Nurse (LPN) # 2 administered 25 of Hydralazine to Resident #9 through his gastrostomy tube. The resident's abdomen was exposed as the nurse checked the placement of the tube and administered the medication and water flushes through the gastrostomy tube. Prior to administering the medication, LPN #2 failed to close the door to the resident's room that led into the hallway and failed to close the privacy curtain around the resident's bed. The resident's wife and daughter were present in the room at the time of the medication pass as well as two (2) other residents present in the hallway outside of the room. During an interview with LPN #2 immediately after the observation, she confirmed the door was not closed and the curtain was not pulled. 2. Resident #1 was re-admitted to the facility on 10/31/11 with diagnoses of Diabetes Mellitus,	F 164	2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Staff Development Coordinator (RN) Educated facility associates from 3/15/12 Through 3/22/12 on providing privacy to residents While providing care. This education included the requirement to ensure the room door is closed, the privacy curtain is completely pulled, and no visitors are in the area unless otherwise preferred by the resident when care is being provided. Associates educated include RN, LPN, C.N.A, Rehab, Administration, Medical Records, Maintenance, Social Services, Environmental Services, Activities, and Dietary departments. 3) What measures will be put into place or what systematic changes will you make to ensure that the deficient practices will not recur? The Staff Development Coordinator (RN) Will complete weekly random verbal testing Of facility associates of resident privacy, And weekly observation on privacy given to Residents during care for three consecutive Months. After these 3 months the SDC will continue the random verbal testing of the facility associates on resident privacy, and observation on privacy given to resident during care monthly for one year.	3/23/12 3/23/12

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F 164	Continued From page 2 Hypertension, Chronic Obstructive Pulmonary Disease, Anxiety and Chronic Renal Disease. The latest Minimum Data Set (MDS) dated 2/2/12 assessed the resident as scoring 13 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. During an observation of wound care conducted on 3/1/12 at 9:20 a.m., the Wound Nurse provided a treatment to the resident's right foot. The privacy curtain was pulled between the two beds in the room but was not pulled around the foot of the bed for Resident #1. The Activity Director opened the door to the room and announced to the resident's roommate in the first bed that she had a visitor in the hallway. Resident #1 was exposed from her upper thighs down with her leg elevated during the treatment. The resident's reflection was visible in the mirror above the sink which could be seen from the middle of the room. The Treatment Nurse or Activity Director did not close the privacy curtain around the resident. As the visitor approached the doorway, the Treatment Nurse pulled the curtain after being questioned about providing privacy for the exposed resident by the surveyor. In an interview with the Director of Nursing on 3/2/12 at approximately 10:00 a.m., she stated the nurses should have pulled the curtain and closed the door before administering the medication and during the wound care.	F 164	4) How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? The Staff Development Coordinator will present The findings of the weekly and monthly random verbal testing of facility associates of resident privacy, and weekly and monthly observation on privacy given to residents during care to the Performance Improvement Committee monthly for three consecutive months, and monthly for one year. The Performance Improvement Committee consisting of the Executive Director, Medical Director, Business Office Manager, Staff Development Coordinator, Wound Care Nurse, Director of Medical Records, Director of Environmental Service, Director Of Maintenance, Director of Social Services, Director of Human Resources, Director of Rehab Services, Director of Activities, Director of Nursing Director of Food and Nutrition Services, and Director of Admissions/Marketing will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.	3/23/12
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	1) What corrective action will be accomplished for those residents found to have been affected by The deficient practice?	

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F 253	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure bathroom faucets were repaired, nail heads were nailed down, light fixtures were intact, holes in walls were repaired, ceiling tiles and linoleum were free from stain and walls were free from cracked and peeling paint for two (2) of two (2) resident units and one (1) of thee (3) common baths. The findings include: During initial tour on 2/28/2012 between the hours of 12:30 p.m. and 1:50 p.m. observations were as follows: 1. The water pressure from the bathroom sink for room one (1) and two (2), was very low. 2. The bathroom for room three (3) and four (4) had five (5) nails sticking out of the tile, behind the toilet and one (1) nail sticking up through the floor around the toilet. 3. The bathroom light fixture for room five (5) and six (6), had multiple cracks. 4. The Rehabilitation common shower had a rusty cover for the cords that were attached to the wall and connected to the outlet, next to the sink. 5. Unit "D" Hall- In the bathroom in Room 20, approximately three (3) holes were present in the wall below the tissue holder	F 253	The Maintenance Assistant replaced The sink and faucet in room numbers One (1) and two (2) on 3/12/12. The water Pressure is adequate in these rooms. The Maintenance Assistant and Director Of Maintenance filed and repaired the Nails sticking out of the tile, behind The toilet, and sticking up through the Floor around the toilet in the bathrooms In rooms three (3) and four (4) on 3/19/12. The Maintenance Assistant and Director Of Maintenance replaced the light fixture(s) In room five (5) and six (6) on 3/19/12. The Maintenance Assistant replaced the Cover for the cords that are attached to the Wall and connected to the outlet, next to the Sink in the Rehabilitation common shower Room on 3/21/12. The Maintenance Assistant repaired the three (3) holes present in the wall below the tissue Holder in the bathroom in Room 20 using Spackling on 3/6/12. The Maintenance Assistant repaired the five (5) holes around the toilet tissue holder in the Bathroom for room 22 and 23 using spackling On 3/9/12. This associate also replaced the Linoleum in this bathroom on 3/23/12.	3/23/12 3/23/12 3/23/12 3/23/12 3/23/12 3/23/12

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F 253	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure bathroom faucets were repaired, nail heads were nailed down, light fixtures were intact, holes in walls were repaired, ceiling tiles and linoleum were free from stain and walls were free from cracked and peeling paint for two (2) of two (2) resident units and one (1) of thee (3) common baths. The findings include: During initial tour on 2/28/2012 between the hours of 12:30 p.m. and 1:50 p.m. observations were as follows: 1. The water pressure from the bathroom sink for room one (1) and two (2), was very low. 2. The bathroom for room three (3) and four (4) had five (5) nails sticking out of the tile, behind the toilet and one (1) nail sticking up through the floor around the toilet. 3. The bathroom light fixture for room five (5) and six (6), had multiple cracks. 4. The Rehabilitation common shower had a rusty cover for the cords that were attached to the wall and connected to the outlet, next to the sink. 5. Unit "D" Hall- In the bathroom in Room 20, approximately three (3) holes were present in the wall below the tissue holder.	F 253	The Director of Maintenance reviewed facility Walls on 3/6/12 for holes, and 20 remaining bathrooms were corrected with spackling. Bathrooms corrected were 24/25, 26/27, 28/29, 32/33, 35/36, 40/41, 42/43, 44/45, 46/47, and 48/49. Three other rooms were Identified to need linoleum, rooms 31, 38, and 40. The Director of Maintenance review the remaining Common shower areas (2) for peeling or cracking Paint, and dark ceiling tiles on 3/13/12. No further Issues were found. The Director of Environmental Services reviewed The remaining resident bathroom linoleum for Dark brown stains on 3/16/12. Four other bathrooms Were noted to have dark brown stains. The Maintenance Assistant replaced the linoleum In these four bathrooms on 3/23/12. The Director of Maintenance reviewed Remaining resident bathrooms for Nails sticking out of the tile, behind The toilet, and sticking up through the Floor around the toilet in the bathrooms On 3/16/12. No additional nails were found, But some holes were repaired in walls with Spackle. The Director of Maintenance reviewed the light fixtures in the remaining resident rooms on 3/15/12. These light fixtures do not have cracks. The Director of Maintenance reviewed the Cover for the cords that are attached to the Wall and connected to the outlet, next to the Sink in the remaining shower rooms On 3/16/12. No covers are rusty at this time.	3/23/12 3/23/12 3/23/12 3/23/12 3/23/12 3/23/12

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F 253	Continued From page 4 6. Unit "D" Hall- In the bathroom for room 22 and 23, there were five (5) approximately 3-5 inch holes around the toilet tissue holder and the linoleum had dark brown stains. 8. Unit "D" Hall common shower-The upper, 10-inch area around the ceiling on the wall had peeling and cracking paint. Approximately four (4) ceiling tiles around a heating unit were discolored with dark, black stains. 9. Unit "D" Hall- Room 39 bathroom had four (4), 2 to 3 inch holes around the toilet tissue holder. The linoleum was stained with dark, brownish stains around the toilet. 10. Unit "D" Hall-Room 22 had a foot long hole in the wall, next to the room's heating/air conditioning unit. 11. Unit "D" hall- Room 24 had a 5 inch hole on the interior wall, next to bed "A." During an interview with the facility's maintenance Manager and Director, on 2/29/2012 at 11 a.m., he stated the bathroom faucet in Room 1 and 2 needed to be completely changed out. They both confirmed all of the aforementioned findings and stated "Repairs would begin right away."	F 253	3) What measures will be put into place or what systematic changes will you make to ensure that the deficient practices will not recur? The Director of Maintenance will conduct A weekly random water pressure and protruding Nail review of resident bathrooms, and make correction as necessary. This review will be completed for three months, and then once per month for one year. This will be documented in a log as part of the preventive maintenance program. The Director of Maintenance will conduct A monthly review of facility light fixtures, Outlet covers, flooring, and walls for any Needed repairs, and add to the Preventive Maintenance program. This will be documented in a log as part of the preventive maintenance program.	3/23/12 3/23/12
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		

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F 253	Continued From page 4 6. Unit "D" Hall- In the bathroom for room 22 and 23, there were five (5) approximately 3-5 inch holes around the toilet tissue holder and the linoleum had dark brown stains. 8. Unit "D" Hall common shower-The upper, 10-inch area around the ceiling on the wall had peeling and cracking paint. Approximately four (4) ceiling tiles around a heating unit were discolored with dark, black stains. 9. Unit "D" Hall- Room 39 bathroom had four (4), 2 to 3 inch holes around the toilet tissue holder. The linoleum was stained with dark, brownish stains around the toilet. 10. Unit "D" Hall-Room 22 had a foot long hole in the wall, next to the room's heating/air conditioning unit. 11. Unit "D" hall- Room 24 had a 5 inch hole on the interior wall, next to bed "A." During an interview with the facility's maintenance Manager and Director, on 2/29/2012 at 11 a.m., he stated the bathroom faucet in Room 1 and 2 needed to be completely changed out. They both confirmed all of the aforementioned findings and stated "Repairs would begin right away."	F 253	4) How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? The Director of Maintenance will present The findings of the weekly and monthly random water pressure and protruding nail review of resident bathrooms, and the monthly light fixture, outlet cover, flooring, and wall review to the Performance Improvement Committee monthly for three consecutive months, and monthly for one year. The Performance Improvement Committee consisting of the Executive Director, Medical Director, Business Office Manager, Staff Development Coordinator, Wound Care Nurse, Director of Medical Records, Director of Environmental Service, Director Of Maintenance, Director of Social Services, Director of Human Resources, Director of Rehab Services, Director of Activities, Director of Nursing Director of Food and Nutrition Services, and Director of Admissions/Marketing will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.	3/23/12
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? The Dietary Manager updated the care plan For Resident #8 on 3/5/12 to reflect MD recommendation to continue Health shakes and weekly weights.	3/23/12

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F 280	Continued From page 5 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, the facility's policy review, and staff interview, the facility failed to revise the care plan for an at risk resident already experiencing impaired nutrition for one (1) of four (4) residents reviewed for weight loss out of a total sample of 24 residents (Resident #8). In addition, the facility failed to revise the plan of care for one (1) of 24 sampled residents, Resident #5 who had a history of multiple falls. The resident sustained 7 falls from 2/10/11 to 2/15/12. The facility ' s failure to revise and update the care plan resulted in the resident sustaining two falls, one of which resulted in harm from a fall out of a wheelchair on 12/10/11. Subsequently, the resident sustained another fall on 2/15/12 from her wheelchair while in the dining room unattended. The findings include:	F 280	The RN MDS Coordinator updated the Care plan for Resident #5 on 3/22/12 To reflect all current fall interventions. 2) How will you identify other residents Having the potential to be affected by the same deficient practice? The Resident at Risk Committee, including The Dietary Manager, Director of Nursing, Director of Social Services, and a Physical Therapist reviewed residents who have had A significant weight loss (5% and 10%) on 3/6/12. Residents who are at risk for weight Loss have interventions care planned. The RN MDS Coordinator and the ADON (RN) reviewed the care plans for residents At risk for falls, and residents with repeat Falls on 3/20/12 to 3/23/12. Residents are risk for falls have care planned interventions. 3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The Resident at Risk Committee will Review residents with significant weight Loss, or residents whose weights have Declined weekly and ensure that interventions Are in place and care planned per MD order. The dietary manager or LPN/RN will document the interventions for these residents in the meeting minutes and resident's chart during this meeting. This committee will meet weekly per policy indefinitely.	3/23/12 3/23/12 3/23/12 3/23/12

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F 280	Continued From page 6 1. Cross Refer to F325. Res on sample Resident #8 was admitted to the facility on 7/24/09 with diagnoses which included Esophageal Reflux, Vitamin Deficiency, Senile Dementia, Insomnia, Constipation, Generalized Pain, Visual Discomfort, Osteoporosis, Arthritis, and Urinary Tract Infection (UTI). The most recent quarterly Minimum Data Set (MDS), dated 1/24/12, coded Resident #8 as requiring supervision (oversight, encouragement or cueing) and one person physical assistance with eating. In addition, the 1/24/12 MDS indicated Resident #8 weighed 108 pounds (lbs.). The previous MDS, dated 11/3/11, coded Resident #8 as requiring only set-up help and weighing 111 lbs. Resident #8 was observed with a thin frame during initial tour on 2/28/12 at 1:06 p.m. Review of the resident's Weight Change History revealed a weight of 119 lbs. on 8/5/11. Review of Resident #8's care plan, developed 8/18/11, revealed potential for weight loss r/t [related to] leaving 25% or more at most meals and a goal for her to lose no weight over the next 90 days (11/30/11); Resident currently within her IWR [Ideal Weight Range] of 99 -121 pounds. The care plan approaches were (1) Serve regular diet as ordered by physician, (2) Milk TID [three times a day] with meals and fortified foods BID [two times a day], (3) Increase Vitamin C beverage BID, yogurt with supper, (3) Dietician and/or CDM [Certified Dietary Manager] to evaluate and follow up at least quarterly, (4) Update food	F 280	The Falls Committee will review residents At risk for falls weekly for three months, And ensure that MD approved interventions Are in place and care planned. The RN will document the interventions for these residents in the meeting minutes and resident's chart during this meeting. This committee will meet weekly per policy indefinitely. The Falls Committee includes the ADON, MDS Nurse, Rehab Services Manager, Activities Director, Social Services Director, and Staff Development Coordinator. 4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Nursing will present The findings of weekly significant weight loss review, And the weekly resident at risk for fall review to the Performance Improvement Committee monthly indefinitely. The Performance Improvement Committee consisting of the Executive Director, Medical Director, Business Office Manager, Staff Development Coordinator, Wound Care Nurse, Director of Medical Records, Director of Environmental Service, Director Of Maintenance, Director of Social Services, Director of Human Resources, Director of Rehab Services, Director of Activities, Director of Nursing Director of Food and Nutrition Services, and Director of Admissions/Marketing will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.	3/23/12 3/23/12

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F 280	Continued From page 7	F 280		

preferences, (5) Monitor food intake at each meal and record. Report any decline to Physician and Dietician, (6) Weigh resident per facility protocol. Report any trends for Physician and RD [Registered Dietician], and (7) Obtain lab work as ordered by Physician. Report results to Physician when available. The care plan was updated with the approach of 60 ml Med Pass® BID x 21 days on 8/30/11

Review of the resident's Weight Change History revealed a weight of 115.2 lbs. on 9/6/11. Review of the Nutritional Progress Note dated 9/26/11, revealed "Intake declining; average daily intake 55%. Resident frequently refusing her Med Pass®. ? [change] supplement to Health Shake TID [three times daily]. Continue to monitor intake, weight, & [and] labs as available." Therefore the resident's care plan was updated with an approach of Health Shake with each meal provided on tray as of 9/27/11 and the Med Pass® was discontinued. Med Pass and Health Shake are balanced fortified nutrition drinks to provide supplemental calories and protein for weight gain.

Review of the Weight Change History revealed Resident #8's weight continued to decrease to 113.8 lbs. on 10/5/11 and to 110.6 lbs. on 11/4/11. Review of the Nutrition Data Collection/Assessment form, dated 11/14/11, revealed ". . . Meal consumption < est. [established] needs and note progressive, not sig [significant], wt [weight] loss over time. Receives Shakes TID . . . Fort [fortified] food BID & Milk TID. F/U [follow up] in RAR [Resident At Risk] mtgs [meetings] by CDM. Review of the RAR meeting minutes, dated 12/05/11 revealed, "Add

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	03/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RHEA COUNTY	7824 RHEA COUNTY HWY DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 8	F 280		

fortified cookie to lunch. Request appetite stimulant from Physician."

Review of the Weight Change History revealed Resident #8's weight decreased further to 109.6 lbs. on 12/15/11. The Nutritional Progress Note, dated 12/27/11, revealed "Wt 109.6 # [pounds]; Note progressive wt loss . . . Consumes 50%, . . . FF [Fortified Foods] BID, Milk TID & H/S [Health Shake] TID. Will add ice cream . . . as rt [resident] has refused Med Pass supplements."

Resident #8's weight continued to decline to 108.4 lbs. on 1/12/12 and to102.0 lbs. on 2/3/12 as documented on her Weight Change History. Even though the resident continued to experience weight loss, no additional approaches were implemented by the facility after 12/27/11.

Review of the facility's 'Nutrition Intervention Program Overview: Nutrition Assessment Process' policy, dated 7/23/09, revealed "Based on a resident's comprehensive assessment, the Interdisciplinary Team ensures that acceptable nutritional status, as defined by parameters of body weight, hydration, and protein levels, is maintained, unless a resident's clinical condition demonstrates this is not possible. The emphasis is on the prevention and/or early detection of the development of any nutritional concerns. The resident's care plan is developed and modified as needed to remain current with problem/concern identification, goals, and interventions."

During an interview with the Certified Dietary Manager (CDM) on 3/1/12 at 6:30 p.m., she explained the resident's care plan wasn't updated because she didn't trigger significant weight loss

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	03/02/2012

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F 280	Continued From page 9 on her last MDS. 2. Cross Refer F323. Resident #5 was admitted to the facility on 8/31/06. Her diagnoses include Alzheimer's disease, Rheumatoid Arthritis, and history of Deep Vein Thrombosis. Review of the most recent Minimum Data Set (MDS), dated 12/27/11, revealed the resident had severely impaired cognitive skills, required 2 person assistance with surface -to-surface transfers (transfer between bed and chair or wheelchair), and was totally dependent on staff for locomotion on and off the unit, toileting and bathing. The MDS also assessed the resident as requiring extensive assistance with dressing and personal hygiene, and with impaired range of motion on both sides of her lower extremities. The Care plan initiated on 4/30/11, which included the goal, "Will minimize risk for falls with serious injury during the next 90 days (4/4/12). The approaches included: (1) Assist to bed or recliner after supper meal. (2) 9/2/11 Resident to be put to bed after supper, the same approach as previously stated. The care plan was not revised to reflect the falls that were occurring outside of scheduled meal times or outside of her room: 1) 2/10/11 at 4:00 p.m. (before supper) in residents room, 2) 2/16/11 at 6:00 p.m. in resident's room, 3) 6/27/11 at 9:00 p.m. (after supper and location not documented), 4) 9/1/11 at 7:20 p.m. (after supper) in hallway, 5) 12/10/11 at 10:30 a.m. (before lunch) in Dining Room, and 6) 2/15/12 at 3:00 p.m. (before supper) in Dining Room. Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), on 3/2/12 at 3:15 p.m., revealed the resident had non-slip material added to the wheelchair after the fall on	F 280		

RES. on sample

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	03/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RHEA COUNTY	7824 RHEA COUNTY HWY DAYTON, TN 37321

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F 280	Continued From page 10 2/10/11. This intervention was documented on the care plan attached to the Incident Follow-up & Recommendation Form but was not brought forward to the present care plan dated 4/30/11. They also verbally confirmed the resident should not be left unattended. This intervention was not documented as an approach on the current care plan. Review of the facility ' s "Falls Management" policy, documented, " ...Procedure : e.) The care plan is reviewed throughout the course of treatment by the interdisciplinary team to assure the most recent, updated, and resident specific fall reduction interventions have been incorporated as necessary into the plan of care."	F 280		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, review of Certified Nursing Assistant's (CNA) Daily Care Guide, and the Incident Follow-up & Recommendation Forms, the facility failed to implement the plan of care for one (1) of 24 sampled residents, Resident #5 who had a history of multiple falls. The resident sustained 7 falls from 2/10/11 to 2/15/12. The care plan for Resident #5 indicated staff transfer the resident with a lift and two person assist, and not to leave the resident unattended while in the wheelchair in room. The facility's failure to follow these	F 282	1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? The RN MDS Coordinator updated the Care plan for Resident #5 on 3/2012 To reflect all current fall interventions. Staff Development Coordinator (RN) completed Care Guide utilization training with Certified Nursing Assistants on 3/22/12, with a focus On following fall precautions with residents At risk for falls. 2) How will you identify other residents Having the potential to be affected by the same deficient practice? The Staff Development Coordinator and Completed mechanical lift(s) competencies On Certified Nursing Assistants on 3/22/12. The SDC educated facility associates on how to check for falls. These associates were nursing, dietary, environmental services, maintenance. administration. activities and therapy	3/23/12 3/23/12 3/23/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	03/02/2012

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LIFE CARE CENTER OF RHEA COUNTY	7824 RHEA COUNTY HWY DAYTON, TN 37321

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F 282	Continued From page 11 on sample new WC interventions resulted in the resident sustaining two falls, one of which resulted in harm from a fall out of a wheelchair on 12/10/11. Subsequently, the resident sustained another fall on 2/15/12 from her wheelchair while in the dining room unattended. The findings include: Cross Refer to F323. Review of the care plan, dated 4/30/2011, documented the following approaches: (1) Transfer with lift and two (2) person assist for safety, (2) Assist to bed or recliner after supper meal, and (3) do not leave resident unattended in room while in wheelchair. Review of the CNA's "Daily Care Guide," dated 3/1/12, for Resident #5, revealed the following interventions: "Do not leave resident up in wheelchair unattended in room. Place resident in recliner or in bed. Hoyer lift with transfers, use two (2) to assist." Observation on 2/29/12 at 10:14 a.m., revealed the resident sitting in a wheelchair, nodding off to sleep beside the medication cart on the short hall across from the Nurse's station. Alarm on wheelchair, attached to the resident. The Hoyer lift sling was under the resident in wheelchair. On 12/10/11, Resident #5 sustained a fractured nose and left index finger which resulted after a fall from her wheelchair. The Incident Follow-up & Recommendation form dated 12/10/11, documented, "Resident in dining room lying in floor face down 10:30 a.m. with bleeding forehead and skin tear to forefinger treated per protocol and x-rayed." The "Witness Statement	F 282	3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The ADON (RN) will complete a weekly Visual audit of fall interventions for residents At risk for falls based on the care plans/guides For three months. After this time, a unit manager, LPN/RN, will complete this visual audit monthly thereafter. This will be maintained on a log for the Fall Committee. Education to staff, and modifications to the Plan of interventions will occur as necessary. 4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Nursing will present The findings of weekly and monthly fall intervention audit to the Performance Improvement Committee monthly thereafter. The Performance Improvement Committee consisting of the Executive Director, Medical Director, Business Office Manager, Staff Development Coordinator, Wound Care Nurse, Director of Medical Records, Director of Environmental Service, Director Of Maintenance, Director of Social Services, Director of Human Resources, Director of Rehab Services, Director of Activities, Director of Nursing Director of Food and Nutrition Services, and Director of Admissions/Marketing will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.	3/23/12 3/23/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	03/02/2012

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F 282	Continued From page 12	F 282		

Form" completed by the CNA, dated 12/10/11 at 10:30 a.m., documented, "This morning when I was coming back from lunch break I walked by the dining room and (resident's name) was lying in the floor face down. I ran down the hall and found the nurse (name of nurse). The care plan was not followed by leaving the resident unattended in the dining room resulting in the resident sustaining a fractured nose."

On 9/27/11, Resident #5 sustained bruises to her upper extremities which resulted after a fall from the stand up lift. Review of the Incident Follow-up & Recommendation Form, dated 9/27/11 documented, "Resident was being transferred with stand up lift and when the Certified Nursing Assistant (CNA) turned her toward bed she slipped through lift."

On 2/15/12 at 3:00 p.m., Resident #5 sustained another fall from her wheelchair while in the dining room. The Incident Follow-up & Recommendation Form dated 2/15/12, documented, "Resident was sitting in floor in front of w/c. She states she slid out." CNA "Witness Statement Form" dated 2/21/12 at 3:52 p.m., documents, "I was walking to the back to do vitals. As I passed the new side dining room I saw (calling name of resident) sitting in front of her wheelchair. It appeared that she had slid out of her chair. I asked her if she was ok. She said she was not hurting. I then ran to get help. Me and some other Associates assisted her."

Review of the facility's "Falls Management" policy, documented, " ...Procedure : e.) The care plan is reviewed throughout the course of treatment by the interdisciplinary team to assure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	03/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RHEA COUNTY	7824 RHEA COUNTY HWY DAYTON, TN 37321

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F 282	Continued From page 13 the most recent, updated, and resident specific fall reduction interventions have been incorporated as necessary into the plan of care." An Interview conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), on 3/2/12 at 3:15 p.m., confirmed the resident was left unattended in the dining room. The DON and ADON also revealed the CNA, who no longer works at the facility, was reprimanded about leaving the resident unattended in the dining room, and needed further education on fall risk. Further interview with the ADON, on 3/2/12 at 3:30 p.m., with the care plan in hand, confirmed the resident was supposed to have 2 person assist by staff when using the lift to transfer the resident. During an interview with the Director of Nursing (DON) on 3/2/12 at approximately 3:45 p.m., she confirmed that everything on the CNA Daily Care Guide was up to date. If there were any changes to the resident's care, the Daily Care Guide would reflect it.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on group interview, staff interview and record review, the facility failed to ensure that showers were provided as scheduled for one (1)	F 312	1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? Resident #22 received a shower by a C.N.A As scheduled each Monday, Wednesday, And Friday from 3/5/12 through 3/19/12. These dates include 3/5/12, 3/7/12, 3/9/12, 3/12/12, 3/14/12, 3/16/12, and 3/19/12. C.N.A. #7 received one on one education by The Staff Development Coordinator (RN) On 3/15/12 on completing showers, and Notifying a supervisor if unable to complete scheduled showers timely.	3/23/12 3/23/12

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	445494	A. BUILDING _____ B. WING _____	03/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RHEA COUNTY	7824 RHEA COUNTY HWY DAYTON, TN 37321

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F 312	Continued From page 14 of 12 residents attending group, Resident #22. The findings include: res. on sample During group interview conducted on 2/29/12 at 3:30 p.m., Resident #22 stated she had a problem getting her showers. She stated she was supposed to get a shower Monday and did not get it. The resident also stated it happened more than once. Further interview conducted after group, revealed she can wash the front of her body but need assistance with the rest. Review of the Daily Shower Schedule documented Resident #22 was scheduled for showers on Mondays, Wednesdays and Fridays. Review of the "Monthly Flow Report" completed by Certified Nursing Assistants (CNAs) documenting "Daily Care" for February 2012, revealed the resident had not received showers on 2/3/12, 2/6/12 and Monday, 2/27/12 (Monday). Interview conducted on 3/2/12 at approximately 4:15 p.m., with CNA #7, revealed she was assigned to provide care for Resident #22 on Monday, 2/27/12. The CNA stated she did not give the resident a shower on Monday because she did not have enough time. Interview with the Assistant Director of Nursing (ADON) on 3/2/12 at approximately 8:45 a.m., confirmed they were having problems with CNAs giving showers. She also revealed the facility conducted an in-service on 2/2/12 regarding showers. The ADON stated facility staff were required to sign in. Review of the Inservice sign in sheet revealed CNA #7 was not on the list as	F 312	2) How will you identify other residents Having the potential to be affected by the same deficient practice? Assistant Director of Nursing (RN) Completed an audit of resident showers For timely completion on 3/21/12. Residents Scheduled to have showers have received Showers timely unless they have refused. This was confirmed by the ADON Reviewing documentation on The "Monthly Flow Report" completed By Certified Nursing Assistants (C.N.A's). Staff Development Coordinator (RN) Completed education with C.N.A.'s on 3/22/12 on completing showers, and Notifying a supervisor if unable to complete Scheduled showers timely. Education to C.N.A's will occur as necessary. Showers will be reassigned if necessary to ensure resident receives number of showers scheduled per week are given. This education will also be completed upon orientation of new C.N.A's by the Staff Development Coordinator. 3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The ADON (RN) will complete a weekly, audit for 3 months and monthly thereafter, of the "Monthly Flow Report" for timely resident shower completion by C.N.A's. Education to C.N.A's will occur as necessary. The unit manager, LPN, will conduct random Interviews with intercviewable residents on Receiving showers as scheduled	3/23/12 3/23/12 3/23/12 3/23/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	03/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RHEA COUNTY	7824 RHEA COUNTY HWY DAYTON, TN 37321

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F 312	Continued From page 14 of 12 residents attending group, Resident #22. The findings include: During group interview conducted on 2/29/12 at 3:30 p.m., Resident #22 stated she had a problem getting her showers. She stated she was supposed to get a shower Monday and did not get it. The resident also stated it happened more than once. Further interview conducted after group, revealed she can wash the front of her body but need assistance with the rest. Review of the Daily Shower Schedule documented Resident #22 was scheduled for showers on Mondays, Wednesdays and Fridays. Review of the "Monthly Flow Report" completed by Certified Nursing Assistants (CNAs) documenting "Daily Care" for February 2012, revealed the resident had not received showers on 2/3/12, 2/6/12 and Monday, 2/27/12 (Monday). Interview conducted on 3/2/12 at approximately 4:15 p.m., with CNA #7, revealed she was assigned to provide care for Resident #22 on Monday, 2/27/12. The CNA stated she did not give the resident a shower on Monday because she did not have enough time. Interview with the Assistant Director of Nursing (ADON) on 3/2/12 at approximately 8:45 a.m., confirmed they were having problems with CNAs giving showers. She also revealed the facility conducted an in-service on 2/2/12 regarding showers. The ADON stated facility staff were required to sign in. Review of the Inservice sign in sheet revealed CNA #7 was not on the list as	F 312	4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Nursing will present The findings of weekly and monthly "Monthly Flow Report" audit for timely resident shower completion to the Performance Improvement Committee monthly for one year. The Performance Improvement Committee consisting of the Executive Director, Medical Director, Business Office Manager, Staff Development Coordinator, Wound Care Nurse, Director of Medical Records, Director of Environmental Service, Director Of Maintenance, Director of Social Services, Director of Human Resources, Director of Rehab Services, Director of Activities, Director of Nursing Director of Food and Nutrition Services, and Director of Admissions/Marketing will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.	3/23/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	03/02/2012

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F 312	Continued From page 15 having attended the in-service.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review , staff interview and policy review, the facility failed to provide incontinent care in a manner to prevent urinary tract infections for two (2) of 24 sampled residents,(Resident #'s 4 and 5). The findings include: 1. Observation on 3/1/12 at 9:30 a.m., of incontinent care for Resident #4, revealed Certified Nursing Assistant (CNA) #5 did not separate the labia and wash the urethral area. A review of the resident's medical record revealed a urine culture, completed on 1/25/12, with results of Escherichia Coli (E-Coli- a colon bacillus, an indicator of fecal contamination) and Enterococcus faecalis (inhabitants of the human intestinal tract), mixed flora The resident was treated with antibiotic therapy.	F 315	1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? Resident #4 discharged on 3/7/12. 3/23/12 Resident #5 completed antibiotic therapy For E-Coli as of 3/20/12 and shows no current Signs or symptoms of infection. 3/23/12 C.N.A # 5 received one on one education And competency was completed By the Staff Development Coordinator (RN) On personal hygiene care, including proper Incontinent care for a resident on 3/15/12. 3/23/12 C.N.A # 3 received one on one education And competency was confirmed By the Staff Development Coordinator (RN) On personal hygiene care, including proper Incontinent care for a resident on 3/20/12. 3/23/12 2) How will you identify other residents Having the potential to be affected by the same deficient practice? Assistant Director of Nursing (RN) And Unit Manager (LPN) observed C.N.A's providing incontinent care of Residents receiving antibiotic treatment for E-Coli on 3/22/12. C.N.A's provided incontinent Care in a manner to prevent urinary . Tract infections. 3/23/12 Staff Development Coordinator (RN) Completed education and competencies With C.N.A's on 3/22/12 on personal Hygiene care, including proper incontinent Care for a resident. 3/23/12	

#Res 4 expired @ Facility Incont care obs. incl. on sample - Res. #4.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	03/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RHEA COUNTY	7824 RHEA COUNTY HWY DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 16 2. Observation on 3/1/12 at 10:10 a.m., of incontinent care for Resident #5, revealed CNA #3 did not separate the labia and wash the urethral area. Observation and record review revealed the resident had an indwelling catheter. Further record review revealed a urine culture, completed on 2/9/12, with results of E-Coli. The resident was treated with Macrobid 100 milligrams (mg), twice a day for five (5) days. The Physician's Progress Notes dated 2/14/12, documented, "E-Coli UTI, P (Plan): Feminine hygiene education" . During an interview with CNA #3 on 3/2/12 at 11:25 a.m., she confirmed she did not separate the labia to clean the resident's urethral area. Interview with the Director of Nursing (DON) on 3/2/12 at 11:30 a.m., confirmed the CNAs did not perform correct incontinent care. She stated, "staff are suppose to separate the labia, clean down both sides of the urethal area and then down the middle, front to back, using a clean towel each time." Review of the facility's policy entitled, "Personal Hygiene Care for the Female Resident", documents, " ...Procedural Steps: 16. Separate labia and wash urethral area first wiping downward from front to back".	F 315	3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The ADON (RN) will complete a weekly Random audit for 3 months and monthly for one year of incontinent care for residents by C.N.A's. These observations will occur for 5 residents on each hall, and the audit will include visually observing for incontinent care completion in a manner to prevent urinary tract infection. The staff development coordinator will track And trend for UTIs and common organisms. Education will be provided to associates in Areas were non-compliance is noted.	3/23/12 3/23/12
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	03/02/2012

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LIFE CARE CENTER OF RHEA COUNTY	7824 RHEA COUNTY HWY DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 16 2. Observation on 3/1/12 at 10:10 a.m., of incontinent care for Resident #5, revealed CNA #3 did not separate the labia and wash the urethral area. Observation and record review revealed the resident had an indwelling catheter. Further record review revealed a urine culture, completed on 2/9/12, with results of E-Coli. The resident was treated with Macrobid 100 milligrams (mg), twice a day for five (5) days. The Physician's Progress Notes dated 2/14/12, documented, "E-Coli UTI, P (Plan): Feminine hygiene education" . During an interview with CNA #3 on 3/2/12 at 11:25 a.m., she confirmed she did not separate the labia to clean the resident's urethral area. Interview with the Director of Nursing (DON) on 3/2/12 at 11:30 a.m., confirmed the CNAs did not perform correct incontinent care. She stated, "staff are suppose to separate the labia, clean down both sides of the urethal area and then down the middle, front to back, using a clean towel each time." Review of the facility's policy entitled, "Personal Hygiene Care for the Female Resident", documents, " ...Procedural Steps: 16. Separate labia and wash urethral area first wiping downward from front to back".	F 315	4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Nursing will present The findings of weekly and monthly "Incontinent Care Audit" for timely resident shower completion to the Performance Improvement Committee monthly for one year. The Performance Improvement Committee consisting of the Executive Director, Medical Director, Business Office Manager, Staff Development Coordinator, Wound Care Nurse, Director of Medical Records, Director of Environmental Service, Director Of Maintenance, Director of Social Services, Director of Human Resources, Director of Rehab Services, Director of Activities, Director of Nursing Director of Food and Nutrition Services, and Director of Admissions/Marketing will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.	3/23/12
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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F 323	Continued From page 17 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, and review of the Falls Policy, the facility failed to ensure one (1) of 24 sampled residents, Resident # 5, who had a history of multiple falls, was not left unattended when up in wheelchair, and failed to ensure two staff assisted for safety when transferring the resident using a lift. The resident sustained 7 falls from 2/10/11 to 2/15/12. The resident sustained a fractured nasal septum and fractured left index finger during a fall on 12/10/11 while unattended in dining room, and received bruises to her upper extremities during a fall when staff transferred the resident with one person assist instead of two, on 9/27/11. In addition, the resident sustained another fall from the wheelchair while left unattended in the dining room, on 2/15/12. This failure to provide adequate supervision to prevent and/or reduce falls resulted in harm to Resident #5. The findings include: Resident #5 was admitted to the facility on 8/31/06. Her diagnoses include Alzheimer's disease, Rheumatoid Arthritis, and history of Deep Vein Thrombosis. Review of the most recent Minimum Data Set (MDS), dated 12/27/11, revealed the resident had severely impaired	F 323	1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? An RN reviewed the current fall Interventions for Resident #5 on 3/20/12 And confirmed the interventions Are documented on the care plan, C.N.A Care guide, and these interventions are in place. The LPN Unit Manager educated C.N.A's Who care for Resident #5 on 3/22/12 On the residents current fall interventions And how to utilize the "C.N.A Care Guide" Daily to ensure current interventions are being Followed. 2) How will you identify other residents Having the potential to be affected by the same deficient practice? Assistant Director of Nursing (RN) And Unit Manager (LPN) reviewed the Current interventions, care plans, and C.N.A care guides for residents at risk For falls on 3/22/12. Interventions are in place, And the C.N.A care guide and resident Care plans are congruent. The Staff Development Coordinator educated C.N.A's on 3/22/12 on how to utilize the "C.N.A Care Guide" for residents at risk for falls daily to ensure current interventions are being followed. The Interdisciplinary Team consisting Of the Director of Nursing, MDS RN Coordinator, Activities Director, Rehab Services Manager, Dietary Director, and Social Service Director Were educated by the Executive Director On the need for timely and accurate updating of Resident care plans for residents who are at risk For falls, or who have experienced falls.	3/23/12 3-23-12 3-23-12 3-23-12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 18 cognitive skills, required 2 person assistance with surface -to-surface transfers (transfer between bed and chair or wheelchair), and was totally dependent on staff for locomotion on and off the unit, toileting and bathing. The MDS also assessed the resident as requiring extensive assistance with dressing and personal hygiene, and with impaired range of motion on both sides of her lower extremities. Observation on 2/29/12 at 10:14 a.m., revealed the resident sitting in a wheelchair (w/c) , nodding off to sleep beside the medication cart on the short hall across from the Nurse's station. Alarm on wheelchair, attached to the resident. The Falls Care Plan, dated 4/30/11, identified the problem, "Resident is at high risk for falls r/t (related to) impaired mobility, frequent falls, impaired balance, cognitive deficits and muscle weakness." Although the resident was assessed with severe cognitive impairment, the falls care plan revealed the following approaches: 1) Personal alarm in bed and chair. Check placement and function every shift, 2) Transfer with lift and 2 person assist for safety, 3) Assist with positioning, transfers, ambulation as necessary or as requested by resident, 4) Assist to bed or recliner after supper meal. In addition, the following approaches were added as the resident continued to fall: 5) Do not leave resident unattended in room while in w/c on 6/29/11 , 6) Resident to be put to bed after supper on 9/2/11 , 7) Hoyer lift with 2 person [lift] on 9/29/11, 8) Educated staff on fall risk on 12/12/11 , 9) Place resident in recliner or bed when in room on 12/29/11 , and 10)For trial	F 323	All residents are assessed on admission for fall Risk. Residents that are identified "at risk for Falls" will be placed in the Fall Risk program. 3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The Unit Managers (RN) will complete a weekly audit of residents at risk for falls for 4 weeks, then monthly thereafter. This audit will include reviewing the care plans And C.N.A care guides for these residents, and Visually reviewing that interventions are in place. The Unit Managers will educate C.N.A's as New interventions are added for residents at Risk for falls. The Staff Development Coordinator (RN) will educate new C.N.A associates upon Orientation of how to utilize C.N.A Care Guides To ensure that interventions for falls are followed. 4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Nursing will present The findings of weekly and monthly "Resident at Risk for Falls" audit for intervention compliance to the Performance Improvement Committee for one year. The Performance Improvement Committee consisting of the Executive Director, Medical Director, Business Office Manager, Staff Development Coordinator, Wound Care Nurse, Director of Medical Records, Director of Environmental Service, Director Of Maintenance, Director of Social Services, Director of Human Resources, Director of Rehab Services, Director of Activities, Director of Nursing Director of Food and Nutrition Services, and Director of Admissions/Marketing will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.	3/23/12 3/23/12 3/23/12

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F 323	Continued From page 19	F 323		

period till [until] w/c received from therapy, put to bed after lunch for rest period and back up for dinner on 2/21/12. The facility was unable to provide evidence demonstrating the staff received training for Fall Risk on 12/12/11 as outlined in the resident's care plan.

The approach/intervention, "Do not leave the resident unattended in room while in w/c" was discontinued on 12/29/11, after the resident fell from the wheelchair in the dining room and fractured her nose and left index finger on 12/10/11.

Resident # 5's Fall Risk Evaluation documented the resident's score as "18 - 20" from 7/13/11 - 12/11/11. According to the Fall Risk Evaluation, "A resident who scores a 10 or higher is at risk for falls".

Review of the facility's Incident Follow-Up & Recommendation Form and Nurse's Notes, revealed Resident #5 fell seven (7) times between 2/10/11 and 2/15/12, sustaining a fractured nose and Left index finger on 12/10/11. The falls occurred on the following dates:

A. 12/10/11 at 10:30 a.m.
Review of the Nurse's notes, dated 12/10/11 at 10:30 a.m., revealed, "Resident found lying face down on dining room floor. Resident is bleeding from the forehead. Bleeding is stopped by minor cleaning. Steri-strips applied. Further exam reveals right and left forefinger (inner aspect) has a 1 cm (centimeter) skin tear. All wound cleaned with Saf-Clenz and steri-stripped ..." At 11:00 a.m., the Nurse documented that the GNP (Geriatric Nurse Practitioner) is called. Ordered

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F 323	Continued From page 20	F 323		

X-ray of face, left (L) finger, Neurochecks, next 24 hours and immobilize (L) index finger to her next finger after it is x-rayed " .

Review of the Incident Follow-up & Recommendation Form, dated 12/10/11, documented, "Resident in dining room lying in floor face down 10:30 a.m. with bleeding forehead and skin tear to forefinger. Treated per protocol and x-rayed. Recommendations/Actions Taken: Upon investigation found CNA involved needed further education on fall risk. Follow-up: Education one-to-one done with CNA assigned." The "Witness Statement Form" completed by the CNA, dated 12/10/11 at 10:30 a.m., documented, "This morning when I was coming back from lunch break I walked by the dining room and (resident ' s name) was lying in the floor face down. I ran down the hall and found the nurse (name of nurse). The care plan was not followed by leaving the resident unattended in the dining room resulting in the resident sustaining a fractured nose."

Review of the Radiology report, dated 12/10/11, documented, "Clinical Information: cut on forehead, attention index finger. Impression: Slight Deviation of the Boney Nasal Septum towards the Right." A hand written notation beside the Interpreting Doctor's typed name, documented, " Fx, (fracture) nasal septum " .

The Physician's Progress notes, dated 12/13/11 at 1535 (3:35 p.m.), documented, " ...recent fall with head laceration and fx to (L) index finger (linear) ...X-rays 12/10/11 - shows fx nasal septum, fx (L) index finger secondary to fall."

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F 323	Continued From page 21 Interview conducted on 3/2/12 at approximately 3:00 p.m., with the Licensed Practical Nurse (LPN) that assessed the resident after this fall, revealed he could not remember if the chair alarm was on the resident or if anyone else was present in the dining room. The LPN reviewed his documentation in the Nurse's Notes, dated 12/10/11 at 10:30 a.m., and confirmed there was no documentation of the alarm sounding or being attached to the resident. Review of the Nurses Notes and Incident Follow-Up & Recommendation form, revealed no documentation of the alarm being present on the resident during the 12/10/11 fall. B. 9/27/11 at 7:35 p.m. The Nurse's Notes dated 9/27/11 at 7:35 p.m., documented, "CNA stated Resident fell out of standing Lift during transfer. When I entered room, resident was lying on back in floor in front of Bed B's recliner positioned on back, both legs straight, feet resting on foot rest of lift, left arm and shoulder on foot rest of bed-side table. C/O (complain of) mild pain. Redness and bruising noted to BUE (bilateral upper extremities) and right hand. No other injury noted. No S/S (sign/symptoms) of fracture. BP (Blood Pressure) 128/58, T (Temperature) 96.1m Pulse 110, R (Respirations) 20. Resident assisted from floor to w/c then to bed. C. 2/10/11 at 4:00 p.m. "Resident sitting in floor (in room) in front of w/c, sitting upright, both legs forward slightly bent. No injury noted, Assisted to reclining chair. Resident stated she was trying to get up and fell ...Non slip material added to wheel chair to prevent further	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 22 incident." D. 2/16/11 at 6:00 p.m. entry for 4:30 p.m. "Resident sitting in floor in front of wheelchair. Sitting upright, legs forward slightly bent. 6pm Spoke with daughter (daughter's name), daughter requests seat-belt to be added to wheel chair ...no injury. Denies pain. Approach: Do not leave wheelchair in room." E. 6/27/11 at 9:00 p.m. "Resident witnessed by CNA (Certified Nursing Assistant) sliding out of wheelchair (w/c) to floor. When this Nurse entered room, resident was sitting upright on buttocks in floor in front of w/c. No injury noted ... " F. 9/1/11 at 7:20 p.m. "Resident sitting in floor in hallway in a sitting position in front of wheelchair, back against chair, both legs forward, no injury noted, denied pain ...assisted back to w/c then to bed." G. 2/15/12 at 3:00 p.m. (Incident report only) CNA "Witness Statement Form" dated 2/21/12 at 3:52 p.m., documents, "I was walking to the back to do vitals. As I passed the new side dining room I saw (calling name of resident) sitting in front of her wheelchair. It appeared that she had slid out of her chair. I asked her if she was ok. She said she was not hurting. I then ran to get help. Me and some other Associates assisted her." Again, review of the Nurse's Notes and Incident Follow-Up & Recommendation Form, revealed no documentation of the alarm being present on the resident during fall on 2/15/12. Also, there was	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 23	F 323		

no documentation of the 2/15/12 fall reflected in the Nurse's Notes. The Nurse's Notes went directly from a note on 1/17/12 at 12:20 p.m.. to a noted on 2/16/12 at 03:00 a.m.

An Interview conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 3/2/12 at 3:15 p.m., confirmed the resident was left unattended in the dining room and should not have been. The DON and ADON also revealed the CNA, who no longer works at the facility, was reprimanded about leaving the resident unattended in the dining room, and needed further education on fall risk. They also stated one-on-one education was done with the CNA but could not show documentation that education occurred. Further interview with the ADON, on 3/2/12 at 3:30 p.m., with the care plan in hand, confirmed the resident was supposed to have 2 person assist by staff when using the lift to transfer the resident, and confirmed that the resident is not cognitively alert enough to ask for assistance when transferring as care planned. During an interview with the Director of Nursing (DON) on 3/2/12 at approximately 3:45 p.m., she confirmed that everything on the CNA Daily Care Guide was up to date. If there were any changes to the resident's care, the Daily Care Guide would reflect it.

Each shift, the CNAs receive a "Daily Care Guide" at the beginning of their shift which provides them with direction based on the care plan. The following was listed on the CNA's "Daily Care Guide," dated 3/1/12, for the resident: 1) Do not leave resident up in w/c unattended and 2) Place resident in recliner or bed. The aforementioned approaches on the CNA's "Daily

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F 323	Continued From page 24	F 323		

Care Guide" conflict with the resident's most current care plan interventions. In addition to the conflicting approach, interview on 3/1/12 at 10:10 a.m. with CNA #3 assigned to the resident, she stated the resident was not to be left unattended in her room. Furthermore, neither the resident's care plan nor the CNA's "Daily Care Guide" addressed any of the resident's numerous falls that occurred outside of the facility's scheduled meal times as well as the falls that occurred outside of her room.

Based on interview with the DON and ADON, the resident should never have been left alone, but this was never placed on the care plan. Although this approach was added to the CNA "Daily Care Guide," the CNA assigned to the resident was unaware of this approach. This lack of awareness and lack of communication resulted in the resident being left alone again in the dining room and sustaining another fall after the fall with injury.

Review of the facility's Falls Management Policy, with the revised date of December 2006, revealed: "... An interdisciplinary plan of care will be developed, implemented, reviewed and updated as necessary to reflect each resident's current safety needs and fall reduction interventions .... Assessment of Fall Risk & Care Plan Development: e) The care plan is reviewed throughout the course of treatment by the interdisciplinary team to assure the most recent, updated, and resident specific fall reduction interventions have been incorporated as necessary into the plan of care ... Management of Falls: h.) The charge nurse will gather and record as much pertinent data as possible related

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F 323	Continued From page 25 to the fall, take note of the environment in which the fall occurred, and record any potential causal factors and j.) The charge nurses will review and update the care plan as needed to reflect the resident ' s present mobility, safety needs, and will communicate fall reduction interventions to care givers on the unit and in shift report . . . Follow-Up Falls: h.) The Fall Reduction Committee (a sub-committee of Performance Improvement) will review fall trends, analyze data, and determine the need for action plans designed to minimize the risk of falls."	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, the facility's policy review, resident and staff interview, the facility failed to follow up timely with the Physician on a recommendation of an Appetite Stimulant for an at risk resident already experiencing impaired nutrition for one (1) of four (4) residents reviewed for weight loss out of a total sample of 24 residents (Resident #8).	F 325	1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? Physician reviewed resident nutritional status And the Resident at Risk Committee recommendation on 3/7/12 for Resident #8. The physician elected to continue Weights weekly, and health shakes with meals. Physician denied request for new order for Appetite stimulant at this time. The Resident At Risk Committee consists of the Director Of Nursing, Dietary Manager, Wound Care Nurse, Therapist, Social Worker, and Dietician.	3-23-12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 325	Continued From page 26 The findings include: Resident #8 was admitted to the facility on 7/24/09 with diagnoses which included, but not limited to, Esophageal Reflux, Vitamin Deficiency, and Senile Dementia. The most recent quarterly Minimum Data Set (MDS), dated 1/24/12, coded Resident #8 as requiring supervision (oversight, encouragement or cueing) and one person physical assistance with eating. In addition, the 1/24/12 MDS indicated Resident #8 weighed 108 pounds (lbs.). This was a three (3) lb. weight loss and a decline in Activity of Daily Living according to her previous MDS, dated 11/3/11, which coded she only required set-up help with eating and weighed 111 lbs. Resident #8 was observed with a thin frame during initial tour on 2/28/12 at 1:06 p.m. Review of the resident's Weight Change History revealed the following weights (please see below): -119.0 lbs. on 8/5/11 -115.2 lbs. on 9/6/11 -113.8 lbs. on 10/5/11 -110.6 lbs. on 11/4/11 -109.6 lbs. on 12/15/11 -108.4 lbs. on 1/12/12 -102.0 lbs. on 2/3/12 Review of the Nutritional Progress Note dated 9/26/11, revealed, " Intake declining; average daily intake 55%. Resident frequently refusing her Med Pass®. Change supplement to Health Shake TID [three times daily]. Continue to monitor intake, weight, & [and] labs as available."	F 325	2) How will you identify other residents Having the potential to be affected by the same deficient practice? The Resident at Risk Committee, consisting of The Director of Nursing, Dietary Manager, Wound Care Nurse, Therapist, Social Worker, and Dietician reviewed the current status of residents with weight loss on 3/6/12. The Resident at Risk Committee contacted the physician on 3/6/12 for 12 (twelve)residents, and on 3/7/12 for 3 (three) residents and reviewed and received clarification for the plan of care Of these residents. The Executive Director educated the Resident at Risk Committee on 3/20/12, consisting of the Director Of Nursing, Dietary Manager, Wound Care Nurse, Therapist, Social Worker, Dietician, and LPN Unit Manager that an LPN Unit Manager is to contact the residents physician and receive new orders or clarification orders for residents who have received recommendations by the Resident at Risk Committee within 24 hours of the committee meeting. This communication will be documented in the nurses notes. All new admissions will be reviewed weekly for 4 weeks by Resident at Risk committee. All readmits will be reviewed by Dietary Manager. Readmits will be reviewed by Resident at Risk committee if a change in condition has occurred that affects nutritional status.	3/23/12 3/23/12 3/23/12

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F 325	Continued From page 27 Therefore the resident's care plan was updated with an approach of Health Shake with each meal provided on tray as of 9/27/11 and the Med Pass® was discontinued. Med Pass and Health Shake are balanced fortified nutrition drinks to provide supplemental calories and protein for weight gain. Review of the Nutrition Data Collection/Assessment form, dated 11/14/11, revealed " . . . Meal consumption < est. [established] needs and note progressive, not sig [significant], wt [weight] loss over time. Receives Shakes TID [three times a day]. . . Fort [fortified] food BID [two times a day] & Milk TID. F/U [follow up] in RAR [Resident At Risk] mtgs [meetings] by CDM." Review of the RAR meeting minutes, dated 12/05/11 revealed "Add fortified cookie to lunch. Request appetite stimulant from Physician." The Nutritional Progress Note, dated 12/27/11, revealed "Wt 109.6 # [pounds]; Note progressive wt loss. . . Consumes 50%, . . . FF [Fortified Foods] BID, Milk TID & H/S [Health Shake] TID. Will add ice cream . . . as rt [resident] has refused Med Pass supplements." During interview with the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Dietary Manager (DM) on 3/1/12 at 6:30 p.m., they revealed weights are done by the restorative nursing assistant, reviewed by the MDS nurse, and then entered into the facility's electronic system by the DM or Medical Records Nurse. They also explained the DM generates a report identifying residents with significant weight loss which is discussed during the RAR meetings	F 325	3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The Resident at Risk Committee, consisting of the Director Of Nursing, Dietary Manager, Wound Care Nurse, Therapist, Social Worker, And Dietician will review residents at risk For weight loss weekly, and contact The physician and receive new orders or clarification orders for residents who have received recommendations by the Resident at Risk Committee within 24 hours of the committee meeting. This communication will be documented in the nurses notes. The Executive Director will audit the "Review List/Follow Up for Resident at Risk Meeting" form weekly for three months and monthly for one year and confirm that Committee recommendations For weight loss of residents have been reviewed timely with the physician.	3/23/12 3/23/12

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F 325	Continued From page 28 held every Tuesday. Attendees included the DON, Wound Care Nurse, Therapy, Social Worker, DM, and the Dietician if possible. In addition, they stated Resident #8's weight started declining after her fracture in August 2011. Review of the Incident Follow-Up & Recommendation Form, dated 8/6/11, revealed Resident #8 fell and sustained a right femoral fracture. Review of the facility's policy entitled "Nutrition Intervention Program Overview: Weight Monitoring," dated 7/23/09, revealed "Any resident who experiences an unplanned weight loss, significant weight change, or undesirable weight change is assessed and monitored by the Interdisciplinary Team. Each identified resident with a weight change has a current nutrition assessment/progress note. The Interdisciplinary Care Plan team addresses the root cause of the weight loss/poor intake or weight gain, assesses dining needs if indicated, provides realistic and measurable goals, indicates specific and individualized interventions, and more as needed. The nutrition progress notes describe the changes, plan of action, and progress or lack of progress." Resident #8 experienced 8.3% weight loss between 11/4/11 - 2/3/12 (approximately 90 days) and experienced 5.4% weight loss between 1/12/12 - 2/3/12 (less than 30 days). Even though the resident continued to experience weight loss, as of 3/1/12, no follow up was done in reference to a response from the Physician to the appetite stimulant recommended on 12/5/11. This was 88 days later with no response. In	F 325	4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Executive Director will present The findings of weekly "Review List/ Follow Up for Resident at Risk Meeting" audit to the Performance Improvement Committee monthly for one year. The Performance Improvement Committee consisting of the Executive Director, Medical Director, Business Office Manager, Staff Development Coordinator, Wound Care Nurse, Director of Medical Records, Director of Environmental Service, Director Of Maintenance, Director of Social Services, Director of Human Resources, Director of Rehab Services, Director of Activities, Director of Nursing Director of Food and Nutrition Services, and Director of Admissions/Marketing will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.	3/23/12

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F 325	Continued From page 29 addition, no nutrition progress notes were documented in the resident's medical record since 12/27/11 and no modifications occurred with her plan of care since 12/27/11. As of 2/29/12, the resident weighed 103 lbs (one [1] lb weight increase since 2/3/12). During interview with the Physician on 3/2/12 at 12:35 p.m., he communicated he has a lot of residents to follow and it's nearly impossible for him to remember if the appetite stimulant was discussed with him for resident #8. During interview with the resident on 3/2/12 at 1:15 p.m., she stated " The food is okay . . . I never ate all my food in my entire life. I like the ice cream and shakes I receive." During interview with the Dietician and Dietary Manager (DM) on 3/2/12 at 2:00 p.m., they explained the Nursing Unit Manager rounds with the Physician weekly and is responsible for getting feedback on any recommendations made. During an interview with the DON on 3/2/12 at approximately 2:20 p.m., she stated " We [Nursing] dropped the ball and failed to get a response from the Physician on the recommendation for appetite stimulant."	F 325		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice?	

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F 441	Continued From page 30 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the facility's Policy and Procedure for Medication Administration, the facility failed to ensure gloves were removed and hands were washed after administering medications through a gastrostomy tube for one (1) resident (Resident	F 441	The Staff Development Coordinator (RN) Completed one on one education with LPN # 2 on 3/15/12 on "Infection Control during Medication Administration". This included education to Remove gloves and wash hands after Administering medication to a resident With a gastrostomy tube before adjusting Clothing and moving equipment To prevent the spread of infection. The Staff Development Coordinator (RN) Completed one on one education with LPN # 1 on 3/15/12 on "Infection Control during Medication Administration". This included education to Remove gloves and wash hands between Administering eye drops to each eye For residents with orders for eye drops To prevent the spread of infection. 2) How will you identify other residents Having the potential to be affected by the same deficient practice? LPN Unit Managers observed LPN nursing Staff administer medication to residents with Gastrostomy tubes on 3/20/12 to 3/21/12. Nurses administered medication to these residents appropriately. LPN Unit Managers observed eye drop Administration to residents with physicians Orders for eye drops on3/20/12 to 3/22/12. Nurses administered eye drops appropriately.	3/23/12. 3/23/12 3/23/12 3/25/12

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F 441	Continued From page 31 # 9) and between administering eye drops for one (1) resident (Unsampled Resident #1) from twenty four (24) sampled residents. During the medication pass observation conducted on 3/2/12 at 11:05 a.m., Licensed Practical Nurse(LPN) #2 administered a medication through the gastrostomy tube for Resident #9. Without removing the gloves she was wearing when she touched the gastrostomy tubing and equipment, she fastened the abdominal binder, adjusted the clothing and bed sheet before removing her gloves and using hand sanitizer. An observation on 2/29/12 at 4:07 p.m. revealed LPN #1 administered eye drops to Unsampled Resident #1's left and right eye. Without changing her gloves and washing her hands after instilling the first drop in the right eye, she touched the medication bottle and resident's upper and lower eyelid to administer a drop to the right eye. Review of the facility's policy for Medication Administration for Eye Instillation, revealed: "Should both eyes require instillation, wash your hands before treating the second eye." In an interview with the Director of Nursing on 3/2/12 at approximately 10:00 a.m., she stated LPN #2 should have removed her gloves and washed her hands after administering medication through the gastrostomy tube and LPN #1 should have changed gloves between administering eye drops.	F 441	3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The Assistant Director of Nursing (ADON) Will complete a weekly audit of medication Administration technique for residents With orders for gastrostomy tubes, and eye Drops installation for three months, then monthly for one year. The ADON Will audit to ensure that proper infection Control technique is being followed. 4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Nursing will present The findings of weekly "Medication Administration" Audit to the Performance Improvement Committee monthly for one year. The Performance Improvement Committee consisting of the Executive Director, Medical Director, Business Office Manager, Staff Development Coordinator, Wound Care Nurse, Director of Medical Records, Director of Environmental Service, Director Of Maintenance, Director of Social Services, Director of Human Resources, Director of Rehab Services, Director of Activities, Director of Nursing Director of Food and Nutrition Services, and Director of Admissions/Marketing will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.	3/23/12 3/23/12
F 460 SS=D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY	F 460		

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F 460	Continued From page 32 Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation and interview with the Director of Maintenance and Housekeeping, the facility failed to ensure that three (3) resident rooms (Rooms 8A, 29A and 30A) out of twenty four (24) sampled residents had privacy curtains long enough to ensure full visual privacy. The findings include: During the observational tour of the facility conducted on 2/29/2012 at 11:50a.m. along with the Directors of Maintenance and Housekeeping, the privacy curtain in rooms 8A and 29A were two (2) to three (3) feet too narrow in width to provide full visual privacy when fully extended. The Director of Maintenance and Housekeeping confirmed that the curtains were not wide enough. During an observation of incontinence care for Resident #5 on 3/1/12 at 10:10 a.m., Certified Nursing Assistants (CNA) #3 and #4 had to pull the privacy curtain toward the head of the bed to prevent the resident from being exposed when the door to the room was opened and had to pull the curtain around the foot of the bed when the	F 460	1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? The Director of Environmental Services Replaced the privacy curtain in resident Rooms 8A, 29A, and 30A on 3/2/12. The privacy curtains are long enough To ensure full visual privacy. 2) How will you identify other residents Having the potential to be affected by the same deficient practice? The Director of Environmental Services Audited residents rooms on 3/2/12 for Proper width of privacy curtains, and 37 were replaced. These were rooms 1-10, and 20-49. 3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The Director Environmental Services Will audit privacy curtains for proper width to ensure visual privacy weekly For three months, and replace as necessary.	3/23/12 3/23/12 3/23/12

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F 460	Continued From page 33 resident's roommate opened the bathroom door. The curtain was too narrow to provide full visual privacy for the resident during care. In an interview with CNA #3 during the observation, she stated the curtain was too narrow to provide privacy for the resident.	F 460	4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Environmental Services will present The findings of weekly "Privacy Curtain" Audit to the Performance Improvement Committee monthly for one year. The Performance Improvement Committee consisting of the Executive Director, Medical Director, Business Office Manager, Staff Development Coordinator, Wound Care Nurse, Director of Medical Records, Director of Environmental Service, Director Of Maintenance, Director of Social Services, Director of Human Resources, Director of Rehab Services, Director of Activities, Director of Nursing Director of Food and Nutrition Services, and Director of Admissions/Marketing will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.	3/23/12